Focus on benefits for retirees

2005 Open Enrollment Edition

Open Enrollment is from Oct. 15, 2004 through Nov. 15, 2004

In this edition:

REMINDER:

If you are not changing health plans or coverage levels you do not need to send in a form.

If you have dental or are eligible to enroll, you must send in a Delta Dental enrollment form if you want dental coverage.

New Dental Plan for 2005

For Current DBP, Dominion and CIGNA Dental enrollees only

Delta Dental has been awarded the County dental contract effective January 1, 2005. The new Dental plan uses preferred provider networks (PPO) as well as an out-of-network option. This single dental plan will replace the current DHMO from Dental Benefit Providers (DBP) and both the DPPO and DHMO from Dominion Dental. The new Delta Plan will also replace the CIGNA dental coverage currently included within the CIGNA health plan. Kaiser and CareFirst discount dental benefits will continue to be a part of the coverage for those two health plans. **Retirees currently enrolled with Dominion, DBP or the CIGNA health plan DHMO must elect coverage under the new plan for 2005 or their dental coverage will terminate December 31, 2004.**

Retirees must submit a Delta Dental enrollment form to the Retirement Office by November 15, 2004 to have dental insurance in 2005. See page 2 for dental plan design. See page 4 for premium rates.

Health Plan Changes

Listed below is a summary of the health plan changes. Consult your plan brochure or call your health plan for detailed information. See page 4 for premiums for 2005 plan year.

FairChoice+ BlueChoice, Blue Preferred PPO Benefit Changes

- New customer service telephone number. It is 800-296-0724.
- Allergy serum will be covered under medical instead of pharmacy.
- Routine vision care to be offered under Davis Vision. Eye exams covered in full after $10 copayment with participating Davis Vision providers. Discount on eyeware. Call Davis Vision at 1-800-783-5602 for network vision providers.
- Healthy Terms Prenatal Care Management Program will be discontinued.

(Continued on page 2)

Premiums at the 2005 rates will be deducted from the December retirement check.

Benefit Changes to Note *(Continued from Page 1)*

Cigna HMO

- Subject to specific conditions, certain procedures will be covered in the clinical trial stage.
- Genetic testing/counseling – coverage for 3 visits per year will be available, subject to medical necessity.
- Dental coverage no longer included.

Kaiser Permanente HMO

- No benefit changes
- Medicare Plus for retirees will no longer be offered; for the present time, current Medicare Plus subscribers may remain in the group.

DELTA DENTAL PLAN
Comparison of Employee Out-of-Pocket Costs and Plan Design

Coverage	Plan Pays			Benefit Limitations
	In Network Preferred	In Network Premier	Out of Network	
Diagnostic and Preventive	100%	100%	80%	These services are exempt from the deductible
-- Oral exams and cleanings				Twice each calendar year
-- Fluoride treatment				Once each calendar year for dependents under age 19
-- Bitewing x-rays				Once each calendar year, limited to posterior teeth
-- Full mouth or panelipse x-rays				Once each three years
-- Space maintainers				For dependents under age 14
-- Sealants				Only for non-carious, non restored 1st and 2nd permanent molars for dependent children under age 16, limited to one application per tooth
Basic Dental Care	90%	80%	80%	(Deductible Applies)
-- Amalgam (silver) and composite (white) fillings				Composite fillings limited to the upper and lower 6 front teeth
-- Stainless steel crowns				Limited to baby/primary teeth for patients under age 13
-- Oral surgery				Simple extractions
-- Denture repair and recementation of existing crowns, bridges and dentures				Cost limited to ½ the cost of a new denture or prosthesis
Other Basic Dental Care	60%	50%	50%	(Deductible Applies)
-- Oral surgery				Impactions and other surgical procedures
-- Endodontics (root canal therapy)				Repeat treatment is a covered benefit only after 2 years from initial treatment
-- Periodontics (scaling and root planing, soft tissue and bony surgery, including grafts)				Limitation of 2-3 years apply based on services rendered; periodontic cleaning is considered a regular cleaning and is subject to the benefits limitations for regular cleanings
Major Dental Care	60%	50%	50%	(Deductible applies)
--Crowns (single crowns)				Once per tooth every 5 years, and only when existing crown cannot be rendered serviceable; benefit available only if the tooth is damaged by decay or fractured to the point it cannot be restored by an amalgam or composite restoration; crowns for dependents under the age of 12 are not covered.
--Prosthodontics (partial or complete dentures and fixed bridges)				Once every 5 years, and only when an existing prosthesis cannot be rendered serviceable; fixed bridges or removable partials are not benefits for dependents under age 16
Orthodontic Benefits -- Removable fixed appliance therapy and comprehensive therapy -- Lifetime Maximum	50% $2,000	50% $2,000	35% $2,000	(Deductible Applies) For dependent children to age 19
Calendar Year Deductible	$50	$50	$50	Limit of 3 per family
Annual Benefit Maximum	$2,000	$2,000	$2,000	Per member

Group Term Life Insurance Changes Set

- Age-banded **rates** for Group Term Life Insurance optional coverage will **reduce** with the new contract effective January 1, 2005. Premiums for January 2005 are deducted in December 2004.

- **Dependent coverage benefit increases. Premiums remain unchanged.** Effective Jan. 1, 2005, the benefit for dependent coverage increases 25 percent with no change to the monthly premium. In addition, the age of an eligible dependent child will increase to age 23. Retirees who already have dependent group term life coverage will automatically get the higher level for their covered dependent(s).

Group Term Life Insurance Premiums for 2005

Age	**Premium per $1,000/month**
Under 30	$0.07
30 – 49	$0.15
50 – 59	$0.29
60 – 79	$0.47
80 – 84	$4.02
85 – 89	$6.81
90 – 94	$19.99

- Retirees who retired prior to Jan. 1, 1999 will begin paying premiums based on age-banded rates for coverage effective Jan. 1, 2005. There will no longer be a flat rate premium. The County will continue to pay for 50% of the coverage and retirees will pay for 50%. Retirees under age 80 in this group will see a reduction in premiums.

Dependent Life Insurance Coverage

Low Option		Premium
Spouse/Child	$6250/$2500	$2.50
High Option		
Spouse/Child	$12,500/$6250	$5.00

- Retirees age 80 or over who have been enrolled in the County life plan for at least 20 years may elect to reduce their coverage to $12,500 and have the County pay 100% of the premium. (Those with less than $12,500 coverage will maintain their coverage at no cost.) Retirees with less than 20 years in the plan may still reduce their coverage to $6,250 at age 80 and the County will pay half of the premium.

- Reductions at retirement and at age 70 will now be made on the first of the month following the event.

- Retirees at any age may reduce their coverage to a lower coverage option at any time.

Got questions?

Call the specific health plan at the number listed below about plan coverage and identify yourself as a Fairfax County Government retiree. Call the retirement numbers listed below if you have more general questions about premiums, effective dates, changes. Hearing impaired may call TTY 711.

Retirement – Erlinda Trappal 703-279-8216	CIGNA 800-244-6224 www.cigna.com
FairChoice+BlueChoice / BluePreferred PPO 800-296-0724 www.carefirst.com / www.bcbs.com	CareFirst Help Desk -- Betsi Fuhrman 703-324-3474
Kaiser and Kaiser Medicare Plus 301-468-6000 www.kaiserpermanente.org	County Staff – Health Doug Sachs 703-324-3316
Delta Dental 800-237-6060 www.deltadental.com	County Staff – Life Ins. Donna Dowd 703-324-3374

Meet the plans

Representatives from CareFirst BlueCross BlueShield, Kaiser, CIGNA and Delta Dental will be available at two special open enrollment meetings. Stop by to get additional plan information and answers to specific plan questions.

Thursday, Oct. 21
Govt. Cntr. Conf. Room 9-10
1:00-4:30 p.m.

Friday, Nov. 5
Govt. Cntr. Conf. Room 4-5
10:00 a.m.-1:30 p.m.

Health And Dental Insurance Premiums For Retirees
JANUARY 1, 2005 – DECEMBER 31, 2005

	Full Monthly Premium (before applying any subsidy)
FairChoice+BlueChoice	
Individual	$ 433.03
2 Party	$ 850.96
Family	$ 1,251.50
Individual with Medicare	$ 302.40
2 Party with Medicare	$ 598.48
2 Party (1 Medicare/ 1 Non Medicare)	$ 729.08
Family, 1 Medicare	$ 1,185.76
Family, 2 Medicare	$ 1,120.01
Family, 3 Medicare	$ 1,054.27
BluePreferred PPO	
Individual	$ 497.96
2 Party	$ 978.61
Family	$1,439.23
Individual with Medicare	$ 347.77
2 Party with Medicare	$ 688.24
2 Party (1 Medicare/ 1 Non Medicare)	$ 838.44
Family, 1 Medicare	$1,373.49
Family, 2 Medicare	$1,307.75
Family, 3 Medicare	$1,242.00
Kaiser	
Individual	$309.88
2 Party	$604.25
Family	$898.63
Individual with Medicare	$252.56
2 Party with Medicare	$505.12
2 Party (1 Medicare/ 1 Non Medicare)	$560.64
CIGNA	
Individual	$341.87
2 Party	$666.66
Family	$994.84
DELTA DENTAL	
Individual	$26.64
2 Party	$50.33
Family	$82.90

These premiums will begin to be deducted from the December retirement checks.

Information retirees should know about benefits

Retirees may continue County life, health and/or dental coverage provided they elected that coverage within the first 60 days after they retired and have never dropped that coverage as a retiree. The County reserves the right to change or terminate the benefit provided or adjust the premium at any time.

If you have retired from Fairfax County, you should contact the Retirement Agency at (703) 279-8200 or (800) 333-1633 for information about continuation of health coverage.

What does the County pay toward insurance?

Group Term Life -- The County pays for 1/2, 1/3, 1/4 or 1/5 or all of the premium, depending upon the coverage selected. Retirees who elect to continue either basic or basic plus one times salary optional coverage will pay for 1/2 of the premium at age banded rates. Retirees who continue basic plus two times salary optional coverage will pay for 2/3 the premium, basic plus three times optional coverage will pay 3/4 of the premium, and those who elect basic plus four times optional coverage will pay 4/5 of the premium. Retirees who opt to reduce their coverage to $12,500 will pay for 50 percent of the coverage at age banded rates and will have no further contractual coverage reductions. At age 80, retirees with more than 20 years of participation in the life insurance plan are eligible to reduce their coverage to $12,500 and the County will pay the entire premium. Retirees at age 80 who have less than 20 years of participation in the life insurance plan may elect to reduce their coverage to $6250 and will pay for 50 percent of the coverage at age banded rates.

Health Insurance -- Retirees pay the full cost of their health insurance premiums. Retirees age 55 or older, or those retired on a disability, receive a monthly subsidy from the County toward the cost of a County health plan. This subsidy is reflected in the table below:

Years of Service At Retirement	Monthly Subsidy for a retiree under age 65	Monthly Subsidy for a retiree age 65 or older (Note: Subsidy payments for retirees over age 65 are adjusted for Medicare)
5-9	$25	$15
10-14	$50	$25
15-19	$125	$100
20-24	$150	$150
25 or more	$175	$175

Retirees currently receiving the $100 subsidy will be grandfathered at that level unless their years of service entitle them to receive a higher monthly subsidy *Surviving spouses are only entitled to a subsidy if they receive a Joint and Last Survivor benefit.*

Dental Insurance – Retirees pay the full cost of their dental insurance premiums.

Retirees can pay their share of their health and/or dental insurance premiums in one of two ways. If possible, the cost will be deducted from the monthly annuity in the month prior to the month of coverage. If the individual does not receive an annuity or if the retiree's check is not large enough to cover the monthly premiums, the retiree must pay any amount not covered by their annuity by mailing a personal check to the Retirement Agency. Personal checks must be received by the Retirement Agency by the 10th of the month to cover the next month's coverage. Failure to make health and dental insurance payments on time may result in cancellation of the retiree's insurance coverage. Please remit personal checks, enrollment forms and change forms concerning retiree health/dental coverage to:

Checks should be made payable to:

County of Fairfax

Address is:

Retirement Agency
10680 Main Street, Suite 280
Fairfax, VA 22030
(703) 279-8200 (800) 333-1633 fax: (703) 273-3185

Continuous coverage requirement

The County requires retirees to have continuous coverage in a Fairfax County Government (FCG) health and/or dental plan. The County, however, allows the coverage to be transferred from the active County government employee group to the retiree group and vice versa. Transfer to and from the Public Schools is not allowed for purposes of benefits coverage. FCPS is a separate employer. Two examples follow:

Example 1: You are retiring and your spouse is also employed by FCG in a merit position. Your spouse may pick up coverage for both of you and any covered dependents when you retire. If your spouse is already enrolled in a FCG health plan, he or she may add you to the policy by filing a change form with the Department of Human Resources within 60 days of your retirement date.
If your spouse terminates employment with FCG, you may pick up the coverage for both of you and any covered dependents through the Retirement Agency by requesting the coverage within 60 days of your spouse's termination date.

Example 2: You retire from FCG, then return to work for FCG in a merit position. The County will transfer your coverage back to the active employee group if you submit a new enrollment form to the Department of Human Resources within 60 days of your reemployment date. The effective date will be the first of the calendar month following receipt of the enrollment form by the Employee Benefits Division. At termination, your coverage will be transferred back to the Retirement Agency if you complete another form requesting coverage through the retirement group.

If coverage is canceled by the retiree or if a retiree's coverage is dropped because premiums have not been paid, the retiree will NOT be eligible to reenroll.

When can retirees make changes to their coverage?

New retirees have the following options within 60 days of retirement:

- New retirees may continue in the same health plan that they had as active employees until the next open enrollment period as long as they continue to meet the plan's eligibility requirements. **Note:** Kaiser and CIGNA health plans do not provide any coverage for retirees age 65 and older who are eligible for Medicare.
- Retirees who are no longer eligible for coverage in their current plan either due to Medicare or because they live outside of the plan's service area of their HMO must elect other coverage for which they are eligible.

- Drop coverage

Current retirees have the following options:

- Retirees enrolled in the Kaiser Permanente Medicare Plus may transfer to another plan if they become ineligible for membership in that plan. Retirees must live in the Kaiser service area to be eligible for coverage in the plan.

- Retirees who move out of their HMO service area must change to another plan serving the area in which they live. The change must be made within 60 days of the move.

- Retirees who become ineligible for coverage in Kaiser or CIGNA because of Medicare must change to another plan serving the area in which they live. The change must be made within 60 days of becoming eligible for Medicare. NOTE: their coverage will be cancelled with CIGNA or Kaiser on the date they become eligible for Medicare and enrollment in the new plan will be made retroactive to that cancellation date once the enrollment form is processed.

- Retirees may **decrease coverage** (drop coverage or drop family members from their insurance) **at any time**. However, levels of coverage may only be increased outside of an open enrollment period **due to a qualifying change in status**. Changes will take effect on the first of the month after receipt of the form unless another date is required due to the specific qualified event. (see pages 12-14).

Retirees eligible for Medicare

Retirees who wish to continue in a FCG health plan **must apply for Medicare Part A and Part B as soon as they are eligible** for that federal benefit. After they receive Medicare coverage, Medicare becomes the primary source for payment of claims, and the FCG health plan becomes secondary.

Retirees or dependents must submit a copy of their Medicare card to the Retirement Agency showing effective dates of Part A and Part B coverage. The monthly premium for Medicare Part B will be deducted from their Social Security Check. Retirees must submit a copy of their Medicare card to the Retirement Agency as soon as it is available – up to three months prior to the effective dates. Submitting a copy of the card in this timely manner will limit the need for any retroactive adjustments in their check.

For most FCG health insurance plans, retirees with Medicare are responsible for paying the same deductible, co-payment, coinsurance and other out-of-pocket expenses that they would have been responsible for paying prior to receiving Medicare. However, under the FairChoice+BlueChoice plan, referrals for specialists are not required.

Retirees and dependents who have Medicare Part A and Part B coverage may be eligible for reduced health insurance premiums. Retirees who do not apply for and maintain Medicare Part A and Part B coverage will be responsible for the portion of their claims that Medicare would have paid.

Coverage for surviving spouses

Surviving spouses of deceased retirees may continue health, life and/or dental insurance coverage until they remarry. Surviving children may continue their coverage until they become ineligible because of age or loss of dependent status. (Under some circumstances, the surviving family member(s) may be eligible for COBRA. For more information about COBRA, call Human Resources at 703-324-3316). If a retiree or dependent with coverage dies, please contact the Retirement Agency as soon as possible so that premiums can be adjusted. Surviving spouses who are age 55 or older and receive a survivor's benefit from the County are also eligible to receive a monthly subsidy (see chart on page 5) . Surviving spouses who do not receive a survivor's benefit are not eligible for any subsidy. If the survivors are not covered under the retiree's plan at time of retirees' death, they are not eligible for coverage.

If a retirement-eligible active employee dies prior to actual retirement, his/her spouse may continue health and/or dental insurance through the Retirement Agency until he or she remarries. Surviving children may continue their coverage until they are no longer eligible. Surviving spouses of retirement-eligible active employees who are age 55 or older are also eligible to receive a monthly subsidy from the County.

If an employee dies prior to becoming eligible for retirement, the survivors are only eligible for continuation coverage under COBRA.

Kaiser Permanente Medicare Plus Plan

Kaiser Permanente's Medicare Plus plan is available for current members only. The County is currently evaluating if this plan will be offered in the future due to changes in the Medicare Law set to take effect in 2006.

To remain eligible for this coverage (which is identical to the standard Kaiser plan) they must live within the plan's service area (and not reside out of the service area for more than 90 days per year). If the retiree or dependent loses eligibility for this plan, the County will allow the retiree to change to another health plan within 60 days of the loss of eligibility so that he/she is covered in a County health plan continuously.

Retirees under the Kaiser Medicare Plus plan must use Kaiser providers in order to receive non-emergency benefits from Kaiser. However, they may use their Medicare card at other providers to receive Medicare benefits for any covered service.

To disenroll in Medicare Plus, the retiree must complete the necessary Disenrollment Form and return it to the Retirement Office. The retiree (and/or spouse) will be disenrolled upon approval by Medicare.

Long-Term Care Insurance

Retirees, spouses of retirees, surviving spouses of retirees and adult children of retirees may apply for the coverage at any time. Applicants will need to complete an enrollment form and a medical questionnaire and be approved by Aetna. (For more information call Human Resources at 703-324-3437).

Retirees must reside in their plan's service area

All health plans (except Blue Preferred PPO) require retirees to live in one of the zip codes that make up their service area. If your zip code (based on your address on file with the Retirement Office) is not included in the service area, you must elect other coverage. This is true even if you change your address for a short time, if your home is in the service area but the post office with your zip code is out of the service area and even if you have not been notified that your zip code is out of the service area. A general description of the service area for each plan is listed below.

For information about specific zip codes covered by each plan, consult the plan materials or call the customer service number for your plan. If you move outside of the service area of your plan, you MUST notify the Retirement Office and change to a new plan within 60 days of your move. Failure to do so could result in your claims not being paid or the loss of eligibility for coverage under the retiree group.

SERVICE AREAS

FairChoice+BlueChoice

Arlington, Alexandria, Fairfax County and city, Falls Church, Prince William county, city of Manassas, city of Manassas Park, Loudoun County, Leesburg, the entire state of Maryland and DC.

Kaiser and Kaiser Medicare Plus

DC, Maryland: Baltimore, Montgomery, Carroll, Harford, Anne Arundel, Prince George's and Howard Counties and some of Calvert, Charles, Frederick County; Virginia: Arlington, Alexandria, Fairfax, Prince William, Loudoun, Falls Church, Manassas and Manassas Park.

CIGNA

Most of Garrett, Allegany, Washington, Frederick (MD and VA), Carroll, Baltimore, Harford, Howard, Anne Arundel, Montgomery, Prince Georges, Charles, St. Mary's, Cecil, Calvert, DC, Alexandria, Arlington, Fairfax, Loudoun, Prince William, Manassas, Manassas Park, Stafford, Spotsylvania, Winchester, Clarke, Fairfax and Falls Church.,

Information Meetings
Health, Dental, Group Term Life Insurance,
Presented by the HR Benefits Staff and Delta Dental

Monday, Oct. 18 Govt. Cntr. Conf. Room 2-3 9:00-11:00 a.m.	**Friday, Oct. 22** Govt. Cntr. Conf. Room 2-3 9:30-11:30 a.m.
Monday, Oct. 25 Govt. Cntr. Conf. Room 9-10 9:30-11:30 a.m.	**Tuesday, Oct. 26** No. County – Lake Anne Office 3rd Floor – 1:00-3:00 p.m.
Wednesday, Oct. 27 Govt. Cntr. Conf. Room 120C 9:30-11:30 a.m.	**Wednesday, Nov. 3** South Co. – Mt. Vernon Room (221) 9:30-11:30 a.m. and 1-3 p.m.
Thursday, Nov. 4 No. County – Lake Anne Office 3rd Floor – 1:30-3:30 p.m.	**Tuesday, Nov. 9** Massey Bldg – A Level Conf. Room 9:00-11:00 a.m.
Friday, Nov. 12 Courthouse, Jury Assembly room, C Level 10:00 a.m.-noon.	

HEALTH CARE BENEFITS AT-A-GLANCE

FAIRCHOICE+BLUECHOICE

	In-Network	Out-of-Network
Annual Deductible	None	$250 per person (with family coverage, only two family members must meet the deductible).
Yearly Out-of-Pocket Limit	None	$2,500 per person (does not include deductible). Two family members must meet out-of-pocket limit.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered in full.	Covered at 70% of plan allowance after deductible.*
In Hospital Doctors' Services	Covered in full.	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.*
Well Baby Care	Covered in full after $10 co-pay.	Unlimited well child visits to age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services	**Inpatient –** Covered in full for up to 30 days per calendar year;* 90 day lifetime maximum. (Physician covered in full after $25 co-pay for one visit per day up to 30 days per calendar year.) **Outpatient –** Covered in full after $25 per visit co-pay, up to 20 visits per calendar year. *Limit is shared between mental health and substance abuse.	**Inpatient –** covered at 70% of plan allowance after deductible,* up to 20 days per calendar year for covered participants age 23 or older (25 days per calendar year for covered participants under 23). **Outpatient –** visits 1-5 per calendar year: covered at 70% of plan allowance after deductible,* thereafter 50% of plan allowance after deductible for unlimited number of visits.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered in full at approved radiology and laboratory centers, $25 co-pay at approved outpatient department of hospital.	Covered at 70% of plan allowance after deductible.*
Routine Vision Care	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers
Dental Care	Discounts on services provided by participating dentists.	Routine care not covered.
Physical Therapy	Covered in full after $10 co-pay, up to 90 days per condition per calendar year.	Covered at 70% of plan allowance after deductible.*
Emergency Treatment	Covered in full after $50 co-pay for a bona fide accidental injury or medical emergency. (Waived if admitted.) Otherwise benefit will be provided out-of-network.	Benefits provided in-network for a bona fide accidental injury or medical emergency. Otherwise, covered at 70% of plan allowance after deductible.*

HEALTH CARE BENEFITS AT-A-GLANCE

BLUEPREFERRED PPO

	In-Network	Out-of-Network
Annual Deductible	None	$250 per person (with family coverage, only two family members must meet the deductible).
Yearly Out-of-Pocket Limit	$1,000 per person (does not include deductible or co-payments). Two family members must meet out-of-pocket limit.	$2,500 per person (does not include deductible). Two family members must meet out-of-pocket limit.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Inpatient Physician Billed Services	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime covered at 90% of plan allowance.* $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Well Baby Care	Covered in full after $10 co-pay.	Unlimited well child visits to age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services	**Inpatient –** Covered at 90% of plan allowance* up to 30 days per calendar year;** 90 day lifetime maximum**. Physician billed services –** 90% of plan allowance.* **Outpatient –** Covered at 90% of plan allowance,* up to 20 visits per calendar year. **Limit is shared between mental health and substance abuse.	**Inpatient –** covered at 70% of plan allowance after deductible,* up to 20 days per calendar year for covered participants age 23 or older (25 days per calendar year for covered participants under 23). **Outpatient –** visits 1-5 per calendar year: covered at 70% of plan allowance after deductible,* thereafter 50% of plan allowance after deductible* for unlimited number of visits.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Routine Vision Care	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers
Dental Care	N/A	N/A
Physical Therapy	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Emergency Treatment	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*

HEALTH CARE BENEFITS AT-A-GLANCE

	KAISER	*CIGNA*
Annual Deductible	None	None
Yearly Out-of-Pocket Limit	N/A	$1,000 individual co-pay. $2,000 family co-pay.
Lifetime Maximum Benefits	None	None
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay; $0 co-pay for children up to 5 years of age.	Covered in full after $10 co-pay per visit.
Inpatient Hospital Care	Covered in full.	Covered in full.
In Hospital Doctors' Services	Covered in full.	Covered in full.
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime; covered at 50% of allowable charges.	Cover office visits, diagnosis and medical/surgical treatment **excluding** drugs, in-vitro, GIFT, ZIFT, etc. $10 co-pay; plus 50% coinsurance applies to physician's charges for treatment/surgical procedures.
Maternity Care	Covered in full after a $10 co-pay on the first prenatal visit.	Covered in full after a $10 co-pay on the first pre-natal visit.
Well Baby Care	Covered in full; $0 co-pay up to 5 years of age; $10 co-pay per visit thereafter.	Covered in full after $10 co-pay per visit.
Mental Health Services	**Inpatient –** Covered in full when medically necessary. **Outpatient -** $10 co-pay per visit when medically necessary.	**Inpatient –** Covered in full when medically necessary. **Outpatient –** Visits 1-5: $10 co-pay per visit. Visits 6-30: $20 co-pay per visit. Visits 31+; $25 co-pay per visit. **Group –** Visits 1-5: $10 co-pay per visit.Visits 6+: $20 co-pay per visit.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	Covered in full after $10 generic or $20 brand name co-pay at Kaiser Pharmacy; $16 generic or $32 brand name co-pay at community pharmacy; and $8 generic or $18 brand name co-pay for mail order. Ovulation and anorexiant drugs covered in full after co-pay of 50% average wholesale price (AWP). Viagra offered at 100% of the AWP only. Smoking cessation products will be prescribed to members who are in a formal smoking cessation program and shall be charged at 50% of the AWP.	Covered in full after $5 co-pay for generic drugs, $15 co-pay for preferred brand drugs and $35 co-pay for non-preferred brand drugs. Mail order - $15 co-pay generic; $45 co-pay preferred brand name; $105 co-pay non-preferred brand.
Laboratory & X-ray	Covered in full.	Covered in full.
Vision Care	Covered in full after $10 co-pay for optometry (eye refraction exam only) and ophthalmology visits; 25% eyeware discount; 15% initial fitting and contact lens discount.	$10 co-pay for eye exams every 24 months at a participating provider. Dollar allowances provided toward purchase of materials and hardware.
Dental Care	Discounts on services.	N/A
Physical Therapy	Short-term therapy covered in full after $10 co-pay per visit. 90 day limit per incident per contract year.	Covered in full after $20 co-pay per visit. Maximum benefit of 60 visits per contract year.
Emergency Treatment	Covered in full after $50 co-pay per visit. Waived if admitted.	Covered in full after $50 co-pay per visit for emergency room; $25 co-pay per visit for urgent care facility. Waived if admitted

QUALIFYING CHANGE IN STATUS EVENTS

The following events, as specified in Section 125 of the Internal Revenue Code and other federal regulations, govern the occasions when you can enroll, cancel or change your coverage OUTSIDE of the open enrollment period. The requested change must be consistent with the event. If none of these circumstances exist, requests for change cannot be approved. **NOTE**: A voluntary cancellation is not a qualifying event. Whenever a change form or enrollment form is required, it must be filed with the Employee Benefits Division of the Department of Human Resources within 60 calendar days of the qualifying event or loss of coverage, whichever is later.

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Adoption or placement for adoption	Same as for birth	Change form and legal documentation	Same as for birth.	Same as for birth.
Birth	To enroll a newborn child, a change form must be filed with the Employee Benefits Division within 60 days of birth. Failure to file a change form with the Employee Benefits Division within 60 days of birth will result in coverage for newborn not becoming retroactively effective to the date of birth. (Do not wait for the baby's Social Security Number as it may cause you to exceed the 60 day time limit) • If you do not already have family coverage and the change form is not received within 60 days of birth, the child must wait until the next open enrollment to obtain coverage. • Participants who already have family coverage but fail to enroll a new child within 60 days, may add the child later if the child is less than one year old. Coverage begins the first of the month following receipt of the change form.	Change form and a dependent certification form if you are adding a dependent with a different last name.	Coverage begins on the date of birth if the form is received within 60 days of birth. Beyond 60 days, see section "Employee Action Needed".	Participant has 2 party coverage. Child is born on May 5. Change form is received on July 1. Coverage is retroactively effective to May 5th. Special deductions, if needed, will be taken for the pay periods in which an increase of premiums should have occurred with the change from 2 party to family coverage. Participant has family coverage. Child is born on May 5. Enrollment form is received after the 60th day after the birth of the child but before the child turns one year old. Coverage begins the first of the month following receipt of the change form.
Legal custody or guardianship	Same as for birth.	Change form and copy of final custody order.	Same as for birth.	Same as for birth.
Employee moves and no longer resides within the HMO's service area	To change health plans, file an enrollment form within 60 days of the change of residence. To drop coverage, file a cancellation form within 60 days of change in residence.	Cancellation or enrollment form and documentation showing change in address.	Change/cancellation effective the first of the month following receipt of the forms.	Employee moves out of HMO service area July 5. Cancellation/enrollment form received on July 21. Change/cancellation becomes effective Aug. 1.
Divorce	To drop spouse and/or children, file a change form within 60 days of the divorce.	Change form and a copy of the legal document supporting the request.	Coverage terminates at the end of the month of the divorce.	Decree date is April 5th. Spouse coverage terminates April 30th. Maximum of four pay period refund if notification to drop spouse is not received within 60 days of divorce or coverage loss.
	If you have lost coverage through your spouse as a result of divorce, file enrollment form within 60 days of loss of coverage to pick up coverage with the County.	Enrollment form, copy of the legal document supporting the request and a letter from spouse's health plan or employer showing the date the coverage ended.	No break in coverage is allowed. Effective date is determined by the date coverage is lost.	Divorce decree date is April 5th. If enrollment form is filed within 60 days, coverage begins May 1 (assumes coverage under spouse's plan ended April 30). Special deductions may be necessary.
Death of employee	None	None	Coverage terminates at the end of the month of death.	Date of death is March 14. Coverage ceases March 31.
Death of dependent	File a change form or other written notice. Include date of death on the form.	Change form	Coverage terminates the last day of the month in which death occurs.	Dependent dies on June 1. Coverage terminates June 30. Maximum of four pay period refund if notification is not received within 60 days of death or coverage loss.

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Spouse terminates employment or takes a leave of absence, and loses coverage through that employer. Employee must have coverage through County or spouse's employer plan.	To pick up new coverage with the County, file an enrollment form within 60 days of loss of coverage. --- To add spouse/dependents who had been covered under spouse's plan to existing County employee's coverage, file a change form within 60 days of loss of coverage.	Enrollment/ change form, copy of marriage certificate or tax return indicating filing married and letter from spouse's employer or health plan showing date coverage ended, reason coverage ended, type of coverage (health and/or dental), name of insurance company and name(s) of covered participants.	No break in coverage is allowed. Date of coverage is determined by the date of coverage loss.	Spouse terminates employment and loses coverage March 30th. Enrollment form and letter must be received by May 29. Coverage will be retroactively effective as of April 1. Special deductions will be taken to cover missed premium payments.
Employee's spouse returns to work or changes employers. Employee will be covered under spouse's new employer's plan.	To request that County coverage be dropped, file a cancellation form within 60 days of the effective date of the new spouse coverage. Note: Must enroll in a separate stand alone dental plan with spouse's new employer in order to drop County's separate stand alone dental plan.	Cancellation form and letter or form from spouse's employer or health plan showing date employment began, date coverage begins, type of coverage (family, two party, individual), name of insurance company and name(s) of covered dependents..	If cancellation form is received within 60 days of the new coverage, coverage with the County will terminate on the last day of the month. No break in coverage allowed.	Spouse becomes covered under new employer on May 1. Form and letter must be received by June 29. (i.e. documentation is received on June 15, coverage is cancelled on April 30). If request is not received within 60 days, participant must wait until next open enrollment to drop.
Marriage	To add a spouse and any eligible dependents, file a change form within 60 days of the marriage.	Change form, copy of marriage certificate or tax return indicating filing married, and if applicable, dependent certification form. You must also notify Social Security and Payroll of any name change.	Coverage begins the first of the month following receipt of the change form.	Date of marriage is April 1. If change form is received by April 30, coverage becomes effective May 1. If form is not received within 60 days of the marriage you must wait until the next open enrollment to add spouse.
	To drop County health plan coverage because you will be covered by new spouse, file a cancellation form within 60 days of the marriage. Note: Must enroll in separate stand alone dental plan with new spouse's new employer in order to drop County separate stand alone dental plan.	Cancellation form and letter from spouse's employer indicating effective date of coverage, type of coverage and name(s) of covered dependents.	If cancellation or change form is received within 60 days of the new coverage, coverage with the County will terminate the last day of the month. No break in coverage allowed.	Date of marriage (and new coverage) is April 1. Form and letter must be received by May 30 (i.e. documentation is received on May 5, coverage is cancelled on March 31). If request is not received within 60 days, you must wait until the next open enrollment to drop.
Employee or dependent becomes entitled to Medicaid or Medicare	File cancellation form to drop coverage within 60 days of Medicaid or Medicare entitlement.	Cancellation form and copy of Medicaid or Medicare entitlement letter.	No break in coverage is allowed. Date is determined by the date of Medicaid or Medicare entitlement.	Date of Medicare entitlement is Aug. 30. Coverage ends Aug. 31. File change form by Oct. 29.
Employee or dependent loses eligibility for Medicare or Medicaid (must be involuntary)	File enrollment/change form within 60 days of coverage loss.	Enrollment/change form, copy of letter indicating loss of eligibility and reason for loss of Medicaid or Medicare coverage and, if applicable, copy of marriage certificate/tax form.	No break in coverage is allowed. Date is determined by the date of coverage loss.	Medicaid coverage ends March 30. Enrollment form and letter must be received by May 29. Coverage effective April 1.
Court orders (including judgements, decrees or qualified medical child support orders)	File change form to add or drop coverage within 60 days of event (change must be consistent with the court order).	Change form, copy of court order and, if applicable, dependent certification form.	No break in coverage is allowed. Date is determined by the date provided in the court order.	Court order is signed Aug. 5. Coverage becomes effective Aug. 5 or coverage will end Aug. 31. Premiums will be charged for the entire month.
Dependent child reaches age 23	To drop an over age dependent, file a change form within 60 days of the 23rd birthday or coverage loss.	Change form	Coverage terminates the last day of the month in which the dependent child turns 23.	Your child turns 23 on May 19. Coverage ends May 31. Must file change form within 60 days of coverage loss to receive full refund if one is due.
Loss of dependent status (does not apply to spouse)	To drop a family member who no longer qualifies as a dependent, file a change form within 60 days of dependent status change.	Change form and dependent certification form indicating that the child is no longer a dependent.	Coverage terminates the last day of the month that the dependent status ended.	Your dependent child, under age 23 marries on June 5. Coverage terminates June 30.

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Open enrollment of a spouse	If your spouse has a different open enrollment period AND different effective date from the County's, you can change your health coverage election so it will correspond with your spouse's. NOTE: If spouse's effective date for open enrollment changes is Jan. 1, you must make your change during the County's open enrollment period. To pick up coverage with the County, file an enrollment form within 60 days of loss of coverage.	Enrollment form, copy of marriage certificate or tax return indicating filing married, and if applicable, dependent certification form. You must also supply a letter from spouse's employer or health plan showing date coverage ends, reason coverage ends, type of coverage (health or dental), name of insurance company and name(s) of covered participant(s).	No break in coverage is allowed. Date is determined by the date of coverage loss.	Date of coverage loss is June 18. Enrollment form and documentation must be received by August 16. Coverage will be effective June 1.
	To drop coverage with the County, file a cancellation form with 60 days of the effective date of the new coverage.	Cancellation form, and letter from employer or health plan showing reason coverage begins, date coverage begins, type of coverage (health or dental), name of insurance company and name(s) of covered participant(s).	No break in coverage is allowed. Date is determined by the effective date of new coverage.	Effective date of new coverage is January 15. Change form and documentation must be received by March 15. Coverage will be terminated effective January 31.

HIPAA SPECIAL ENROLLMENT EVENTS

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.	EFFECTIVE DATE	EXAMPLE
Employee or dependent exhausts COBRA or loses coverage due to other involuntary reason, including a dependent's loss of coverage due to reaching a specific age.	File enrollment/change form within 60 days of loss of coverage.	Enrollment form, copy of marriage certificate, if applicable, and letter from employer or health plan showing reason coverage ended, date coverage ended, type of coverage, name of insurance company and name(s) of covered participant(s).	No break in coverage is allowed. Effective date of coverage is determined by the date of coverage loss.	COBRA coverage is exhausted Sept. 30. Form and required documentation must be received by Nov. 29. Coverage is retroactively effective to Oct. 1. (Special deductions will be taken to cover missed payroll deductions.)
Uninsured employee acquires dependent(s) due to marriage	File enrollment form within 60 days of marriage. Enrollment form requesting coverage for employee, spouse and, if applicable, newly eligible dependents (i.e. stepchildren).	Enrollment form, copy of marriage certificate or copy of tax return indicating filing married and, if applicable, dependent certification form.	Coverage begins the first of the month following receipt of the enrollment form.	Date of marriage is April 1. Enrollment form received April 25. Coverage becomes effective May 1. (Special deductions will be taken to cover any missed payroll deductions.)
Employee acquires dependent(s) due to birth of child or adoption/ placement of child.	File enrollment form requesting coverage for either employee and newly eligible child or employee, spouse and newly eligible dependents.	Enrollment form, adoption papers and copy of dependent certification form, if applicable, and copy of marriage certificate or tax return indicating filing married.	Coverage begins on the date of birth if the form is received within 60 days of birth.	Child is born on May 5. Enrollment form is received on July 1. Coverage is retroactively effective to May 5. (Special deductions will be taken to cover missed payroll deductions.)